Medical Decisions at the End-of-Life: Lessons from America*

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Bioethical issues that deal with medical decisions at the end of life are as interesting as they are contentious. Daily, we confront questions of health care rationing, medical futility, euthanasia, or the use of advanced directives and ethics committees. There is present-day mainstream thinking on these bioethical themes and more important, under-emphasized and controversial aspects of dying in America.

Modern American bioethics originated in 1962 when Dr Belding Scribner developed the external vascular shunt that made renal dialysis possible. For the first time, patients otherwise doomed to die from renal failure could be treated effectively with hemodialysis. Because there were many more patients than dialysis machines, the University of Washington, where Dr Scribner worked, was forced to form an Admissions Committee to literally decide who would receive dialysis and live, and who would not and die. The seven anonymous lay members of the Committee—cynically dubbed the God Committee—dutifully selected candidates for the lifesaving procedure. Its methodology and criteria for choosing from among "prostitutes, playboys, and poets"[1] were largely unknown. This was America's first ethics committee at work.

American bioethics has matured much over the past 32 years, spurred in January 1980 by the formation of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The Commission studied medicolegal and ethical aspects of informed consent, brain death, human experimentation, access to care, and mental health. But its best known subject was medical treatment at life's end, which was authoritatively published in 1983 under the title "Deciding to Forgo Life-Sustaining Treatment: Ethical, Medical and Legal issues in Treatment Decisions."[2]

As a discipline, bioethics currently attracts more than 2,000 professionals who are drawn from the fields of medicine, law, theology, and the humanities. Bioethicists belong to societies such as the American Society of Law, Medicine and Ethics, and train at institutions like The Hastings Center in New York and The Kennedy Center for Bioethics in Washington DC. Leading medical publications and specialized ethics journals, eg, *The Hastings Center Report*, regularly feature scholarly research, analysis, and editorials on a broad array of ethical issues. And at a practical level, about half of all health care facilities across the nation have formed ethics committees to help them solve patient-care moral dilemmas.

American law, more so than philosophy, religion, or medicine, has helped shape the development of American bioethics.[3] Witness the proliferation of case-laws and statutes that attempt to define bioethical boundaries, beginning with the landmark case of *In re Quinlan*[4] decided in 1976 by the New Jersey Supreme Court. For the first time, a court of law was asked to rule on whether a patient in a persistently vegetative state could refuse mechanical ventilation, even if such refusal resulted in death. Calling it a privacy right that could be exercised on the patient's behalf by her parents, the court ruled that Karen Ann Quinlan's self-determination interest outweighed any real or theoretical opposing interests of her doctors, the hospital, and the State of New Jersey. The decision favored patient autonomy over medical paternalism; more significantly, it injected the law into a clinical arena previously within the exclusive domain of the medical profession.

Subsequent cases before the courts in states like California, Massachusetts, Florida, New York, and Missouri have continued the trend of deciding in favor of the family's wishes to withdraw life-sustaining medical treatment.[2,5] On June 26,1990, the U.S. Supreme Court decided its first right-to-die case in *Cruzan v. Director, Missouri Department of Health.*[6] Stating that "...a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment..." the court went on to characterize artificial fluids and nutrition as a form of medical treatment that could be refused. The *Cruzan* court also held that states may promulgate a standard that there be clear and convincing evidence of a patient's wishes before a surrogate decision-maker can authorize the withdrawal of life-sustaining treatment.

Legislation on patient care issues has also been intense in the past two decades. Virtually all states now have statutes on living wills, informed consent, durable powers of attorney, brain death, and assisted suicide. Federal laws also regulate health care decisions; examples are edicts governing the treatment of disabilities including AIDs and anti-dumping laws.

Of all bioethical issues, those that deal with end-of-life treatment decisions in the aged and the incurably ill generate the most debate. This is because they directly confront life-and-death outcomes, as well as issues of self-determination and health care cost.

*This work was presented at the 20th Annual Seminar of the Medico-Legal Society of Singapore on November 5-6, 1994.

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Living Wills

Patient self-determination is a bioethical principle of recent vintage, an outgrowth of American laws governing privacy or liberty rights. All competent persons are believed to have a fundamental right to control the decisions relating to their medical care. Autonomy underpins many widely accepted Western medical practices such as informed consent and do-not-resuscitate orders. It empowers the patient with the control of his or her body, even for decisions against medical advice.

When patients become seriously ill, they may become confused, delirious or comatose, and therefore incapable of making decisions regarding their treatment. Yet it is important to know their wishes, since some treatment options are invasive and expensive, and may only prolong the dying process while offering little or no reasonable chance of recovery. Patients may not want such treatment.

A living will is a written document prepared by an individual in order to direct future care in the event of medical decision-making incapacity. It is one way of preserving and respecting the patient's right of self-determination. All 50 states have statutes that allow individuals to plan in advance for their medical treatment: California was the first with the enactment of its Natural Death Act in 1976.[7] Hawaii passed its Living Will law in 1986, amending it in 1991.[8]

Living wills permit patients to forgo life-sustaining treatment when they become incurably ill and are no longer able to make or communicate their decisions. Patients may specify the refusal of specific measures such as mechanical ventilation, blood transfusions, dialysis or surgery, or they may choose to forgo all life-sustaining treatment. Medical personnel will always continue to provide comfort care to relieve pain and suffering. Written instructions in the form of a living will have two practical effects: They inform health care providers of the patient's true wishes, and they spare family members the uncertainty and guilt of trying to decide what's best for the patient. The underlying disease is allowed to run its natural course. "Allowing to die" is therefore different from active euthanasia or mercy killing, where a deliberate act is performed to extinguish life.

A living will is a witnessed legal document that becomes operational when the patient is decisionally incapacitated with a terminal illness. Doctors are legally obligated to abide by the patient's instructions; it may be revoked at anytime by the patient.

Three aspects of living wills that deserve attention:

• **Living will statutes may be unduly restrictive or vague.**—For example, "terminally ill" in one jurisdiction[8] was originally defined as death occurring in a "relatively short time." Physicians may not know what this means and have adopted the definition provided by Medicare, the country's health plan for senior citizens, which is death occurring within 6 months. In some jurisdictions, persistently vegetative states and severe irreversible neurological damage do not qualify since these are not terminal conditions. Some laws do not address the withholding or withdrawing of intravenous hydration or tube feedings. For example, Hawaii, initially ambivalent about whether these measures constitute "medical treatment," excluded them from its 1986 law; an amendment in 1991 now permits the discontinuation of artificial hydration and nutrition in terminally ill patients, as well as in those with irreversible neurological conditions that impair decision-making.[8]

• **Durable power of attorney (DPA) is superior to a living will.**—A DPA for health care decisions confers legal authority regarding medical matters on someone (not necessarily an attorney) who is appointed by the principal (patient). This authority takes effect when the latter is decisionally incapacitated.[9] Appointing a DPA for health care is preferable to executing a living will because the patient now has a trusted surrogate who can faithfully reflect the patient's wishes known to him or her or are expressed in a concurrent living will. A living will alone is insufficient. It is a static document, made months or years prior, that cannot possibly anticipate every conceivable clinical situation that might arise in the future. For example, the patient may not have considered specific medical measures such as antibiotics, artificial nutrition or temporary dialysis. Or a new treatment may be imminent. Executing both a DPA and a living will gives the patient the best chance of fully exercising his or her self-determination rights when medically incompetent.[2] Together, the proxy-decision maker, the patient (speaking through his or her living will), and the doctor will decide what is best for the patient.

• **Educate patients and doctors.**—Despite widespread legislation on advance directives, most Americans have yet to execute such a document. The best estimates suggest that less than a quarter of the general population have prepared living wills. Doctors and nurses, who should know better, are no better off.[10] Inadequate public education and inertia in executing a legal document are the likely reasons. Recent federal legislation mandating all hospitals to inform patients of advance directive statutes should prove effective. Called the Patient Self-Determination Act,[11] the law went into effect in December 1991. Yet a study of 302 patients before and after implementation of the Act revealed no difference in patient knowledge. Only 6% were able to identify correctly the meaning and use of both a DPA and a living will, and less than a quarter remembered being given this information.[12] It seems a hospital is not the ideal place to begin the education process.

Living wills should be understandable and easy to prepare. Model forms should be widely available and should incorporate provisions for the appointment of a health care DPA. An effective educational strategy may be to encourage or require physicians to routinely discuss the subject with their patients before they become seriously ill. Special sensitivity is also needed in explaining advance directives to certain ethnic or religious groups. Blacks, for example, may shy away from advance directives for religious reasons or because of a perception of abuse by and distrust of the medical establishment.[13]

Ethics Committees

In the 1960s, some hospitals in the U.S. set up special committees to review decisions regarding abortions, renal dialysis, and human experimentation. Many of the decisions centered around the ethics of autonomy, rationing, or consent, so these early ad hoc groups can be considered the forerunners of our present-day ethics committees. In 1976, a New Jersey court recommended that family and physicians use a hospital ethics committee to resolve cases like *In re Quinlan* (the right to stop life-sustaining treatment) rather than seek judgment in court.[4] This unusual judicial recommendation, the first of its kind ever, provided the impetus for the creation of ethics committees across the country. The President's Commission's report in 1983 further encouraged their formation.[2]

In 1984, the federal government promulgated the Baby Doe rules to prevent the perceived maltreatment of handicapped neonates and infants.[14] The regulations failed to materialize into law, but they led to the proliferation of hospital infant care review committees, which in turn grew into hospital ethics committees.

About half of the 6,000 U.S. hospitals currently have working ethics committees; the percentage is higher in hospitals with more than 200 beds. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) deserves some of the credit for this phenomenal growth. In 1991 JCAHO, which accredits all U.S. health care institutions, wrote into its regulations the requirement that "an organization should have in place a mechanism for the consideration of ethical issues arising in the care of patients and to provide education to caregivers and patients on ethical issues in health care."[15]

In addition to ethics committees, hospitals are required by federal law to have in place Institutional Review Boards that scrutinize research protocols involving human subjects.[16] Finally, many professional organizations such as the American Academy of Pediatrics, the American College of Physicians, and the American College of Obstetrics and Gynecology have formed committees to establish ethical guidelines and policies for their specialties. The American Medical Association, the country's leading doctor organization, likewise has such a committee which regularly updates and publishes its position on ethical issues.[17]

What do hospital ethics committees do? Generally, they perform three functions: First, they influence policies on ethical issues governing patient-care. An example is the hospital DNR (do-not-resuscitate) policy. A current policy struggle of ethics committees concerns the formulation of a coherent approach to futile treatment. Second, ethics committees offer consultations to health care providers and families. These clinical consultations frequently involve difficult treatment decisions. Third, hospital ethics committees sponsor teaching programs to educate their staff and the public. The educational function is the least controversial of the three; some have suggested that it should be the only legitimate function of ethics committees.

The roles of the ethics committee should be clearly differentiated from those of hospital legal counsel and its risk manager.

Notwithstanding their popularity, hospital ethics committees have come under increasing fire for their lack of fairness, consistency, and effectiveness. It has been said that the main value of ethics committees lies in their process and not necessarily their product.[18] Critics also question the appropriateness of the move to immunize committee members and participants from legal liability.[19]

The most controversial aspect of hospital ethics committees is their role in clinical consultations:

• **Who sits on ethics committees?**—Most scholars are critical of committees composed mostly of doctors because of the concern that they alone cannot completely represent the patient's best interests. Doctor-controlled ethics committees are less common today; instead, committees almost universally have multidisciplinary and lay representation. It is important to have lay members, if only because they compel discussions at an everyday understandable level—the same level that is needed to meaningfully inform the patient and family. Nurses and social workers definitely belong on ethics committees, since they spend much time with patients and family, gaining special insight into patient wishes and concerns and family dynamics. Theologians, administrators and philosophers sometimes populate ethics committees; they can provide useful perspectives. One group appears unpopular: Legal counsel. Perhaps it's a reflection of paranoia over lawsuits and legal pronouncements, or simply the belief that the law sets mandatory standards, whereas ethics is aspirational.[3]

Ethics members may be ignorant of ethical principles and health care matters. A recent article decried the laissez-faire approach to ethics committees, and called for the systematic education and training of committee members in order to achieve standards aimed at raising the level of accountability.[18]

• **Who is an ethics consultant?**—Suppose a patient refuses a lifesaving blood transfusion. Family members are reluctant or unable to persuade the patient to change his or her mind. The attending physician is reluctant to coerce treatment and calls for an ethics consultation. Who can respond? Only doctors with training in clinical ethics? The chief of the department? What about a non-doctor ethicist or even the entire ethics committee if it can respond quickly enough?

Ethics consultants may review cases on behalf of the institution's ethics committee on which they serve, or they may offer these specific services without going through a committee. The main advantages of a consultant over a committee are: 1) first-hand direct contact with the patient, family, and health care givers; 2) quick response time; and 3) enhanced accountability. Adding a consultant to an ethics committee, therefore, can be expected to improve its effectiveness in case reviews.[20]

But what training qualifies an individual to be an ethics consultant? There is no U.S. statutory board of bioethics with the authority to certify an individual as a clinical bioethicist. A recent survey[21] asked 154 "ethics consultants" what they would recommend in eight hypothetical variations of the persistent vegetative state. The study revealed wide variations in their recommendations, pointing to the need for standardization. Other studies indicate that the medical fraternity is generally suspicious of non-doctors who make recommendations about their patients. Ethics consultants who are not medical doctors can expect, at least initially, to encounter resistance to their presence on hospital wards.

Finally, should an ethics consultant be paid for services rendered. Currently, most ethics consultations are offered as a hospital service without charge to the patient. Shouldn't the patient or health care insurance payers reimburse the cost of clinical ethics services just as they do for other clinical consultations?

• **Who has access to ethics committees?**—Ethics consultations should be patient-oriented rather than physician-oriented.[22] Ideally, patients and their families as well as all health care professionals connected with the case should be able to access the hospital ethics committee. However, in many hospitals, only members of the medical staff have access, and nurses and patients may be excluded. Because an ethical opinion may be sought where disagreement exists among doctors, nurses, and family, ethics committees should have an "Open door" policy to hear all sides of the issue. Patients and others will view committees that restrict access with suspicion, which in turn undermines their credibility and effectiveness.

• **Decisions by bureaucracy.**—Those bemoaning the increasing bureaucratization of medical decision-making cite ethics committees as one prime example. Dr Mark Siegler, a noted

clinical ethicist, has criticized decisions by committees because they add to the administrative and regulatory burdens on patients, families, and their physicians. Committees usurp the traditional role and responsibilities of the treating physician, replacing him or her with uninvolved moral experts who may have serious conflicts of interest such as minimizing hospital risk or allocating economic resources more efficiently.[23]

Another pitfall is that committees may paradoxically impair rather than improve decision-making. The phenomenon of "group think" may lead to subconscious pressure on members to reach consensus, and to minimize controversy, risks, and objections.[24]

Professor George Annas, arguably America's leading health care lawyer specializing in bioethics, is unenthusiastic about ethics committees for a different reason. He is concerned that a group decision by an ethics committee holds no individual responsible or legally accountable; ethics committees, he believes, should provide "ethical comfort, not ethical cover."[25]

Medical Futility

Consider patients in a persistently vegetative state, which is usually caused by prolonged interruption of brain oxygenation. Oblivious to their surroundings, such noncognitive patients stand no reasonable chance of returning to a sapient state. They require supportive treatment, sometimes needing mechanical ventilators to help them breathe. In the 70s and 80s, the issue was whether doctors could insist on treating such patients against the wishes of the family. In America today, the opposite issue confronts medical practitioners—the issue of medical futility.

If it is clear that families can stop treatment, is it also clear they can demand non-beneficial care against the doctor's medical judgment? Can doctors refuse to provide expensive futile care which neither treats nor palliates? Two recent court cases suggest there may indeed be such a duty to treat under certain circumstances. In the first case, *In re Wanglie,*[26] the New York court upheld the family's request to continue ventilator support of Helga Wanglie, an 86-year-old woman in a persistently vegetative state who had earlier stated her desire for all life-sustaining treatment. In the second case, *In the matter of Baby K*[27] the U.S. Court of Appeals affirmed a lower Virginia court's decision to honor a mother's request that her comatose anencephalic infant (born without a brain) be provided emergency treatment whenever she needed such treatment, instead of being allowed to die.

Because the evolving law appears to favor "pro-life" family decisions, physicians, fearing lawsuits, are understandably reluctant to reject surrogate demands for ineffective therapy. This largely explains the continued use of aggressive futile treatment in hospital wards and intensive care units. Extending, *ad absurdem,* this putative duty to treat, doctors even go so far as to offer options that are clearly unwarranted, eg, cardiopulmonary resuscitation for the patient with terminal cancer. It's a misreading of the law of informed consent, and an example of defensive medicine which, by one estimate, adds $27 billion to annual U.S. health costs.[28]

Might judges be off the mark in their opinions regarding medical futility? The goals of medical practice are to prevent illness, to restore health, to alleviate pain and suffering, and to rehabilitate. These goals are only served by doing what is medically appropriate or indicated. If futile care equals inappropriate care, a family's misplaced demand for such treatment must necessarily yield to medical judgment. Judges and families should defer legitimate clinical decisions to the medical profession. Doctors are bound by the Hippocratic Oath and are trained to make sound clinical judgments. They define the standard of care, and they should stand by it.[3] This is feasible because:

• **Medical futility is definable.**—Simply put, futile treatment is that which cannot reasonably be expected to improve a patient's quality of life. Under this definition, comfort care, which relieves suffering, is *never* futile. On the other hand, cardiopulmonary resuscitation in a comatose terminally ill patient is.

Schneiderman and colleagues[29] have proposed several definitions of medical futility that are practical and useful. They believe physicians should differentiate between treatment that merely results in an isolated effect from that which brings about a general benefit to the patient as a whole. Treatment that fails to provide the general benefit, whether or not it achieves a physiological effect, is futile. Treatment that merely preserves permanent unconsciousness or condemns the patient to existence in the intensive care unit can also be considered futile.

Some insist that for treatment to be deemed futile, it must offer zero chance of a favorable outcome. A more practical approach is to acknowledge that absolute certainty is unachievable in medical prognosis and to accept a no-reasonable-possibility standard. Schneidemman et al offer a quantitative definition of medical futility: Less than one chance in 100.

• **One way to save medical costs—accept death?**—Medical expenses are apt to be particularly high at the end of life. About 30% of all Medicare payments each year are for the 5% of beneficiaries who died in that year; about 40% of the medical bill in the last year of life is spent in the last month.[30] It has been suggested that a good part of these expenditures may be for futile invasive treatment rather than for comfort and compassionate care, a perversion of high-touch by high-tech.

Because physicians can never be certain whether or when death will occur, some commentators have challenged the view that these end-of-life expenses are unnecessary or wasteful. They calculate that relatively little savings will result even if we take positive steps like advance directives, hospice care, and the elimination of futile treatment.[31]

Rationing

Most wealthy nations spend 7% to 9% of their GDP on health care. By contrast, the U.S. leads the world by consuming 14%, or nearly $1 trillion. Neonatal care in the intensive care unit can cost upward of $2,000 a day. Major medical procedures such as coronary bypass surgery top $20,000, and organ transplants cost even more; when follow-up care and medications are totaled, the bill exceeds $100,000.

Mired in this milieu of medical megabucks are 37 million Americans, a quarter of them children, who cannot afford health insurance and therefore forgo ready access to health care. Prenatal care is patchy, and many children are not properly vaccinated. These factors largely account for our high infant mortality rate of 9.2 per 1,000. In contrast, Singapore boasts a figure of 5.5, Canada 7.2, and the U.K. 8.4. Our life expectancy, at 75.2 years, trails Canada's 76.4, Singapore's 75.7, and the U.K.'s 75.6.[32]

Even in a crisis of affordability, no caring society can allow its sick to go without medical attention. Ethically we must insist on universal access. Yet America does not wish to surrender its lead in biotechnology, medical innovations and quality care. The

trick is to satisfy these needs within an affordable health care budget, to structure a system that delivers all three: Quality, accessibility, and affordability. Can health care ever be like the good, fast, and cheap McDonald's hamburger? Or do we believe those who tell us that health care, for better or for worse, can only serve up any two, but never all three?

Enter rationing. Many consider this morally indefensible, forgetting that we already ration care by implicitly limiting the reach of 37 million uninsured Americans. Under one scenario, the new rationing will provide coverage irrespective of the ability to pay, but what is provided will be basic and adequate, not comprehensive. Those who want more will have to pay for the extras themselves. Adequate care does not translate into everything with the slightest hope of medical benefit. As in the family budget, affordability dictates what we might have to do without.

Is providing such a basic package to all, but allowing the individual to buy additional coverage, ethically justifiable? This is two-tiered medicine. It favors the rich, and it is practiced in most countries of the world. We in the U.S. so far have resisted its implementation, but the current health care debate centering on affordability is forcing us to reconsider the issue. Should money buy a second or third opinion, the best available surgeon, a private nurse? Surely there are limits. Should it ever be allowed to buy a kidney?

What will the law say about attempts to limit care in the name of saving money? In America's litigious society, we can expect lawsuits to proliferate. *Newsweek* recently described lawsuits as the "weapon of choice" against those who would limit medical services.[33] This past year, Nelene Fox successfully sued Health-Net, an HMO, for its denial of a bone-marrow transplant to treat her breast cancer. Ignoring defense evidence that such treatment was experimental, the jury awarded her $89 million in damages.[33]

Another recent case provides a useful perspective on the subject of rationing. In the summer of 1993, a pair of Siamese twins were born to the Lakebergs. The twin sisters, Amy and Angela, shared a common heart and liver. In an urgent and desperate operation, surgeons in Philadelphia attempted to separate the joined organs. They were prepared to sacrifice Amy for the infinitesimal chance of saving her sister Angela. Unfortunately both died. The cost of the tragedy was estimated at $1.3 million.[33]

In caring for its poor and its uninsured, Oregon recently set up a list of 696 diagnoses and procedures ranked in order of medical priority. The state legislature funded up to number 565, and excluded items such as heroic treatments for the incurably ill and most types of plastic surgery. Although not without its critics, the courageous and realistic Oregon Plan has received approval from Washington after being previously spurned by the Bush Administration. The nation will be watching closely whether Oregon's rationing scheme proves to be a workable model of cost-containment in health care delivery.[34]

• **Age as a criterion for rationing.**—Several leading philosophers in the U.S. have proposed that age be used as a criterion in the rationing of medical care, reasoning that such limits are justifiable because each citizen would benefit over the course of the individual's lifetime (every citizen was once young). Thus, age discrimination differs fundamentally from sex or race discrimination since these latter classes would be denied from birth an equitable share of health care resources. Callahan[35] in particular has made the point that citizens should substitute "communalism for individualism," and accept death at the end of a natural life span both for their own sake and for the sake of others. Extending the logic of his argument, he has called for the cessation of medical research directed at extending life.

The fascination with using age as a criterion follows the dramatic demographics of aging in the U.S. and elsewhere. Currently, those over the age of 65 comprise 12% of America's population; this figure will rise to 20% by the year 2020. The elderly consume a disproportionate share, almost a third, of health care spending.[36-37] And, in contrast to Asian values,[38] American attitudes tend to glorify youth and devalue the elderly.

It is not always clear whether these philosophers are talking about limiting routine medical care, intensive care, or futile treatment of the elderly. Few would wish to limit routine, comfort and compassionate care for any patient, young or old. On the other hand, it is easy to argue that medical treatment that extends life devoid of human qualities should not be undertaken. But that argument applies irrespective of age.[39]

The matter of limiting intensive care for the elderly is probably what's being contemplated. It deserves closer study. Recent data indicate that the long-term outcomes of hospitalized critically ill elderly patients are remarkably good.[40] Compared to a control group (ages 65 to 74), elderly patients 75 years or more did not differ in length of hospital stay, hospital charges, mortality at 1 year, or quality of life. Most were willing to receive intensive care again, if necessary. Such results have prompted a call for re-examining the common assumptions about health care in the elderly.[37]

Limiting elderly health care is assumed to result in substantial savings. Levinsky has questioned this conventional wisdom,[39] high cost hospital admissions account for less than 3.5% of Medicare expenditures; the withholding of all routine medical care from the elderly is believed to be necessary before substantial savings can be achieved. Restricting research that extends the natural life-span has been criticized as naive, since research cannot be compartmentalized (the example is given that penicillin prevents rheumatic fever in the young and extends the lives of the elderly with pneumonia). Finally, Levinsky argues that the noneconomic costs of a national policy to limit health care to the elderly would be substantial, since it is politically unpopular and is likely to exacerbate the tension between the generations.

Euthanasia

More than any other controversy in health care, euthanasia palpably confronts the life-and-death decision. It ranks as one of America's premier ethical dilemmas, and its most emotional.

Supporters of euthanasia assert an individual has the ultimate right to choose death, and there is no moral difference between allowing a person to die, which is legal, and active euthanasia, which is not.[41] They point to the medical profession's insensitivity toward alleviating pain and suffering at the end-of-life as the raison d'etre in their demand for death control and death with dignity.

Opponents of euthanasia deny such an absolute right to be killed: Allowing the underlying disease to take its course is fundamentally different from an overt act whose purpose is to extinguish life.[42] They also argue that life is sacred and that hospice care and better doctor education have resulted in improved comfort measures for the terminally ill.

• **The slippery-slope argument.**—Many fear that legalizing euthanasia may unintentionally victimize the weaker members of society. What begins as allowing free choice would slide into subtle encouragement to end life; mental coercion and involuntary euthanasia without explicit patient requests lie short steps away. The handicapped, the poor and the aged would be the most vulnerable. A review of MDEL (medical decisions concerning the end of life) in the Netherlands, where euthanasia is condoned, supports this slippery-slope argument.[43] The lack of explicit request was found in 1,000 patients who were euthanized in 1990 to 1991. Such abuse concerns led to the narrow 54 to 46 rejection of recent *aid-in-dying* initiatives in Washington and California.[44]

The euthanasia assault on the Hippocratic Oath argues ill for American society plagued by family rupture, mindless violence, and increasing discrimination. While claiming to be autonomy-centered, active euthanasia stands to dangerously expand the ethical boundaries of rationing and medical futility.

• **The double-effect phenomenon.**—Aggressive treatment toward abating pain and suffering at life's end may result in an earlier death for the patient, since medications such as morphine are powerful respiratory depressants. This unintended result of accelerating the dying process is not wholly unanticipated. Doctors, therefore, worry about the wrongfulness of this so-called "double-effect" phenomenon. Physician fear of criminal or civil backlash may be the basis for the dramatic under-use of narcotics (both dose and frequency) to alleviate the suffering of the dying patient. It has been estimated that in as many as 80% of patients, pain is not relieved effectively.[45]

Bioethicists have universally considered the morally supportable double-effect phenomenon to be fundamentally different from euthanasia or physician-assisted suicide. Their reassurance may not be enough. Laws immunizing physicians from liability in this area may be necessary to gain the confidence and support of an increasingly skeptical profession. A change in physician mind-set toward the double-effect phenomenon will ensure better comfort care in terminally ill patients.

• **Is legalized euthanasia likely?**—Like the abortion fight culminating in *Roe v. Wade*[46] more than two decades ago, the euthanasia battle is being waged with increasing stridor and cacophony. The country appears intensely interested and evenly divided on this issue. A how-to monograph on suicide entitled *Final Exit* became a runaway best-seller.[47] And a survey of 938 physicians in Washington revealed that a slight majority favored legalizing physician-assisted suicide and euthanasia in at least some situations, although most would be unwilling to participate in these practices themselves.[48]

The recent court verdict absolving Dr Jack Kevorkian, a pathologist who assisted in the mercy-killing of 18 patients in Michigan, will fuel the national drive to legalize euthanasia. Initial rebuffs at the ballot box in California and Washington notwithstanding, pro-choice advocates can be expected to redouble their efforts to achieve their goal. This November, Oregonians will be voting on an aid-in-dying initiative that sanctions the request for drugs to end life. Liberal Oregon supports legalized rationing, and it is home to The Hemlock Society, the nation's leading right-to-die organization. Early betting favors passage of this initiative. If passed into law, this initial victory for supporters of legalized euthanasia will serve as a powerful catalyst for the passage of similar laws across the country.**

Conclusions

My personal experiences and my reading of the bioethical and medicolegal trends in America lead me to offer the following overview:

1. America should be applauded for its insistence on respect for patient autonomy, but it should be more willing to accommodate physician paternalism. Most of all, it must recognize when autonomy ought to yield to societal values that preserve the common good.
2. Lawyers and the courts are overly intrusive in patient-care matters. Like Damocles' sword, the law hangs over the heads of health care providers, frequently impeding rather than fostering their efforts to look after the best interests of their patients.
3. Doctors must not abdicate their duty and privilege as the patient's ultimate advocate.
4. The health care crisis in America is one of affordability rather than access. To preserve the excellence of our health care system, we simply must restore self-discipline and spend within our health care budget.
5. Equal comprehensive health care for all is an illusion, even if it is politically correct. But we must insist on basic adequate coverage for all, irrespective of age or the ability to pay.
6. Futile treatment confers no benefit on patients, and wastes health care dollars. It should be abandoned.
7. Overall patient and societal benefit should inform and guide the decision to treat, to withhold treatment, and to allocate scarce health care resources.

**On November 8, 1994, voters in Oregon enacted Measure 16 that legalizes the prescribing of medications for terminally ill patients seeking to end their lives.

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